DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

CORRECTED

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 03 - 0 0 2

2. STATE: New Mexico

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
April 1, 2003

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ XX AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
Section 1902 (a) as amended

7. FEDERAL BUDGET IMPACT:
a. FFY 2004 $ 740,000
b. FFY 2003 $ 370,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19 - B Pages 7b, 7c & 7d

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
TN 01-02
Current Page 7b ~~is replaced in its entirety~~
Pages 7c and 7d - ~~reference change~~
~~New page~~ TN 01-02
TN 01-02

10. SUBJECT OF AMENDMENT:
To re-index the FQHC / RHC rates to reflect the cumulative percentage difference between the increase in the medical care component of the consumer price index - urban (CPI-U) and the increase in the Medicare Economic Index (MEI)

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ XX OTHER, AS SPECIFIED:
State Medicaid Director

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Beege A. Hall
for

13. TYPED NAME:
Carolyn Ingram

14. TITLE:
Director, Medical Assistance Division

15. DATE SUBMITTED:
January 12, 2004

16. RETURN TO:
Carolyn Ingram, Director
Medical Assistance Division
Human Services Department
P.O. Box 2348
Santa Fe, NM 87504-2348

Attn: Doyle W. Smith

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: ~~13 JANUARY 2004~~ 30 June 2003

18. DATE APPROVED: 2 FEBRUARY 2004

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
1 APRIL 2003

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
ANDREW A. FREDRICKSON

22. TITLE:
ASSOCIATE REGIONAL ADMINISTRATOR
DIV OF MEDICAID & CHILDREN'S HEALTH

23. REMARKS:

RECEIVED

FORM HCFA-179 (07-92)

Instructions on Back

Once the base period rate for each FQHC and RHC has been calculated, any claims paid for dates of service on or after January 1, 2001, that were paid an interim rate, will be reprocessed. This reprocessing will adjust the payment on each claim to the PPS base rate amount.

d. Updates to PPS base rates:
Beginning in Federal Fiscal Year (FFY) 2002, and each year thereafter, each FQHC and RHC payment amount (on a per visit basis) will be increased by the percentage increase in the Medicare Economic Index (MEI) for primary care services. This adjustment to the PPS rate will be effective each October 1.

e. Alternative Reimbursement Methodology
An alternative reimbursement methodology will be implemented effective April 1, 2003. This alternative methodology will re-index the PPS rates in effective March 31, 2003 by the cumulative percentage difference between the increase in the Medical Care Component of the Consumer Price Index-Urban (CPI-U) for the 12 months in the calendar year 2001 and the increase in the Medicare Economic Index (MEI) effective for calendar year beginning January 1, 2002, and the increase in the Medical Care Component of the CPI-U for the 12 months in calendar year 2002 and the increase in the MEI effective for the calendar year beginning January 1, 2003. The new rates will be effective April 1, 2003. Thereafter, beginning in Federal Fiscal Year 2004, an evaluation of whether the MEI or the CPI-U will be used as the inflation index to adjust the PPS rates will take place but in no event will the increase be less than the increase in the MEI.

The initial rate for a new provider entering the program will be established either by reference to payment rates to other clinics in the same or adjacent areas with similar caseloads. Or in the absence of such other clinics, through cost reporting methods. Once the initial rate for the new provider is determined, it shall be updated in accordance with other provisions of this rule. A new (additional) location, established by an existing provider participating in the Medicaid program, will receive the same rate as the parent company or organization establishing the additional clinic, unless it can demonstrate a significant change in scope or intensity of services.

f. Change in Scope of Services
Once the PPS Rates are determined as outlined in this section, adjustments to those rates will reflect changes in the scope of services will be made upon the written request of the provider and approval by MAD. A provider's request for a PPS rate adjustment due to a change in scope of service must be received no later than 90 days after the provider's fiscal year end during which the change in scope of service occurred. The provider should notify MAD in advance of any impending changes. The provider will be required to submit data supporting that a change in the scope of service transpired. This documentation will include FQHC and RHC information report and any other supporting documentation considered necessary by MAD or its designee.

A minimum of six months should have elapsed since the change in the scope occurred to ensure the change was not temporary and that there is sufficient information upon which to base a rate adjustment. If the change in scope of service occurred in the last six months of a FQHC's and RHC's fiscal period, MAD may require the FQHC and RHC to submit and additional information report, covering at least six months since the change in scope of service transpired, to obtain the information necessary to evaluate the request.

MAD and/or its designee will review the request and determine if an adjustment to the established PPS rate is merited. The following criteria will be used to evaluate each FQHC request for a rate adjustment due to a change in scope of service. MAD's final determination will be communicated to the FQHC and RHC in writing.

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1. MAD or its designee will evaluate each request for a rate revision due to a change in scope of service. If it is determined that a significant change in the scope of service has occurred, the reasonable incremental cost per encounter from this change will be added to the PPS rate and a new rate established. This new rate will be effective on the date the change in scope of service has not transpired, no adjustment will be made to the encounter rate.

2. The events that could create a change in the scope of services are defined to include, but are not limited to, such things as significant expansion or remodeling of an existing clinic, the opening of an additional satellite clinic (new site), addition of new services, deletion of existing services, or other changes in the scope/intensity of services offered by a clinic that significantly increase or decrease the clinic's costs, relative to its PPS rates. A change in scope of services will not be considered to have transpired unless it increases or decreases an FQHC's and RHC's cost per encounter by more than 2.5%.

g. Managed Care Wrap-Around Payments:
MAD will pay a supplemental 'wrap-around' payment for managed care organization (MCO) encounters. FQHCs and RHCs must submit invoices, on a regular basis (at least quarterly), but no more frequently than monthly, which identify the number of encounters per each MCO. Supporting documentation must be provided upon request.

1. Interim Wrap-Around Payment Percentages:
MAD will pay a percentage of the FQHCs and RHCs PPS rate as the wrap-around payment. MAD will determine this payment percentage, with input from its designee and from each FQHC and RHC. MAD's determination will be communicated to each FQHC in writing. Wrap-around payments will be made directly by MAD, not as a pass through from the managed care entity.

2. Final Settlement of MCO Encounters:
On an annual basis MCO encounters will be settled. This process will be done to reconcile MCO encounter payments to the PPS rate(s). To perform this reconciliation total payments due will be calculated by multiplying MCO encounters by the PPS rate(s). MCO payments and Interim Wrap- Around payments received during the period will then be subtracted from the total amount due. Any over or under payment

determine from this reconciliation will be made as a lump sum settlement.

The provider must submit the documentation required to perform the final settlement within 150 days of their fiscal year end. The reconciliation will them be performed by MAD or its designee within 150 days of receipt of all required information

3. Change in MCO Payments:

If a clinic renegotiates its payment rates with an MCO, the clinic is required to notify MAD that this occurred within 30 days of the effective date of this change. Upon receipt of this information, MAD may re-determine the FQHCs and RHCs interim wrap-around percentage. MAD may also periodically request MCO payment / rate information from the MCOs to determine if the interim wrap-around payment percentage should be reestablished.

h. Initial Rate for New FQHCs and RHCs:
The initial PPS rate for new FQHC and RHC providers will be established either by reference to payment rates to other clinics in the same or adjacent areas with similar caseloads, or in the absence of such other clinics, through cost reporting methods. Once the initial PPS rate for the new FQHC and RHC is determined, it shall be updated in accordance with other provisions of this rule.

A new (additional location, established by an existing FQHC and RHC participating in the Medicaid program, will receive the same PSP rate as the parent company or organization establishing the additional clinic, unless it can demonstrate a significant change in scope or intensity of services, as defined in section VIII.f has occurred. This provision does not, however alleviate the clinic's responsibility to be licensed and to otherwise comply with Medicaid certification and other requirements for participating in the Medicaid program.

i. Information Reporting Requirements:

1. Annual Filing Requirements for FQHCs and RHCs:

All FQHCs and RHCs will be required to file and annual information report with MAD. This report is for general information purposes of MAD. The

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